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SUMMARY: GLOBAL PAYMENT

Definition. Global payments are fixed-dollar payments for the care that patients may receive in a given time period, such as a month or year. Global payments place providers at financial risk for both the occurrence of medical conditions as well as the management of those conditions.

Intended Effects. Global payments are intended to contain costs and reduce the use of unnecessary services, encourage integration and coordination of services. Global payment may also include added incentives improve the quality of care.

Incentives for Providers. Providers have an incentive to constrain costs so as not to exceed the global payment amount. Global payments may provide incentives for providers to integrate services in order to manage risk, especially when payment covers services in multiple settings. Health plans may use a number of provisions to limit risk that global payments entail for contracting providers, offering an incentive for providers to take on the financial risk inherent in global payments, and reducing incentives to either withhold necessary services or avoid potentially high-cost patients.

Potential Problems. Global payment arrangements might induce providers to "stint" on necessary care and to "cherry pick" less expensive patients. Global payments can entail significant administrative complexity, requiring technical infrastructure and personnel devoted to managing financial risk. Small provider groups or solo practitioners may not be able to take on risk associated with global payment approaches. Regulatory issues around monitoring financial solvency of providers arise in cases of significant risk transfer.

Experience with Implementation. Global payment approaches are not new; they exist to some degree in many parts of the United States., primarily in the form of capitation payment arrangements. However, the prevalence, types, and extent of these risk-sharing arrangements vary by region or market area.

Impact. Studies have shown that payment approaches involving risk-sharing with providers—including global payment or capitation—are associated with lower service use and cost, compared with fee-for-service arrangements. There is relatively little research on how global payment arrangements affect longer term outcomes such as provider integration or coordination of services across settings.

GLOBAL PAYMENT

1. What is it?

Global payments are fixed-dollar payments for the care that patients may receive in a given time period, such as a month or year. Global payments typically are paid on a per-patient basis; they do not vary with the actual amount of services that are delivered. Global payments may cover all or some costs of care for enrollees—including physician, ancillary or hospital services, and prescription drugs (Kongstevdt 2001; Hurley et al. 2002; Commonwealth Fund 2009).

Global payments bundle services at the *patient* level, versus a service or episode level. They place providers at risk for both the occurrence of medical conditions (insurance risk) and management of those conditions (clinical risk). Consequently, they transfer significant risk from the health plan to contracting physicians and hospitals (or entities representing both). Global payments may be based on the expected costs of the covered services over the contract period. Usually they are estimated from past cost experience, they may be adjusted based on various risk factors such as the enrollee's age, sex, and the expected progression of a current medical condition.

To address provider concerns about assuming financial risk, health plans that use global payments may add a number of provisions to limit or reduce providers' financial exposure for costs beyond the provider's control, associated with unusually high-cost patients (Kongstvedt 2001,Walker 2001). Global payment approaches also may include provider performance incentives (similar to some pay-for-performance payment approaches), such as bonus payments for meeting performance targets on various quality measures.

2. Intended effects

Global payments are intended to contain costs and reduce the use of unnecessary services, and (in the longer term) encourage integration and coordination of services. Global payments may encourage improvements in the quality of care through specific incentives or because contracting providers may expect quality improvements to reduce the costs of care.

3. Incentives to providers

Because global payments place providers at risk for costs that exceed the expected total cost of all services patients may use during the contract period, providers have an incentive to constrain costs so as not to exceed the global payment amount. Global payments may provide incentives for providers to integrate services and perhaps consolidate into larger organizations in order to manage risk, especially when payment covers services in multiple settings. Larger organizations may be better able to cost-effectively coordinate services across the multiple settings that the global payment covers (Walker 2001). In addition, they benefit from the "law of large numbers" in managing financial risk—that is, by taking on financial risk for more patients, larger organizations can reduce the potential impact of a few very sick patients on their total cost.

Health plans may use a number of provisions to limit risk that global payments entail for contracting providers, offering an incentive for providers to take on the financial risk inherent in

global payments, and reducing incentives to either withhold necessary services or avoid potentially high-cost patients.

- *Stop loss* limits a provider's risk that a patient will require services costing more than a specific amount (called the attachment point). Stop loss limits contracting providers' "down side" risk, but allows them to keep payments that exceed patient cost.

- *Reinsurance* reduces provider risk above the attachment point, but may not limit it. Reinsurance typically holds providers responsible for a percentage of the cost of services provided above the attachment point.

- *Partial capitation* involves the use of global payments for services that are more predictable care (such as primary care), but not all of the care the patient may require.

- A *risk corridor* sets upper and lower limits on the contracting provider's financial risk per patient. While risk corridors limit the amount of losses a provider may sustain, they also limit provider profits (Kongstvedt 2007).

A related approach is *blended capitation,* which calculates expected costs based on a blend of cost bases, such as local, regional, or national cost experiences. This approach accounts for local cost variation and practice patterns and provides incentives to achieve broader state or national standards for cost or utilization performance.

Global payment approaches may also include supplemental provider payments for performance, based on selected quality measures. Intended to encourage evidence-based, high-quality care, such performance payments have been relatively common in capitated contracts between health plans and group medical practices, which pass practice-level performance incentive payments on to physicians (Reschovsky and Hadley 2007).

4. Potential problems or drawbacks

Potential problems or issues related to global payment involve concerns about access, quality, and equitable provider payment. Absent efforts to ensure the delivery of evidence-based care, global payment arrangements might induce providers to "stint" on necessary care and to "cherry pick" less expensive patients. This has long been a concern about the effects of various managed care products on provider behavior (Robinson 2001; Pauly and Nicholson 1999; Miller and Luft 1997*)*

Global payments can entail significant administrative complexity. Because global payments place providers at significant financial risk, setting appropriate payments typically involves risk-adjustment, limiting the impacts of high-cost "outlier" patients, and equitably paying different types of providers. Global payments also require payers assign patients to particular providers for the purpose of making payments; this can be challenging in a delivery system where patients receive care from many different providers (Pham et al. 2007)

Finally, small provider groups or solo practitioners face significant challenges in managing the financial risk associated with small numbers of patients, where a few outliers can drive up average cost. Small groups may not have the administrative infrastructure needed to track and manage costs under global payments.

Given the significant implementation issues related to financial risk sharing with providers, a working group of the National Association of Insurance Commissioners (NAIC) issued guidance to states regarding managed care organizations' (MCOs') creation of "down-stream" risk. In a bulletin written for insurance commissioners, the NAIC working group stated that, "if a health care provider enters into an arrangement with an individual, employer or other group that results in the provider assuming all or part of the risk for health care expenses or service delivery, the provider is engaged in the business of insurance...[and] must obtain the appropriate license (see www.netreach.net/~wmanning/naicrsk.htm). Regulatory issues relating to transferring risk to providers are in many cases handled by the states. An important issue for states is the extent to which regulators should monitor the fiscal status of medical groups under risk-sharing contracts as it relates to financial performance and solvency (Brown and Eagan 2004).

5. Experience with implementation

Global payment approaches are not new; they exist to some degree in many parts of the United States, primarily in the form of capitation payment arrangements. However, the prevalence, types, and extent of these risk-sharing arrangements vary by region or market area.

Risk-sharing with providers has been most common in markets with a history of large medical groups or integrated delivery systems—including metropolitan areas in California, Minnesota, and Massachusetts. While highly integrated group or staff model plans (such as Kaiser Permanente) have used global payments for decades, many other types of health plans have developed risk-based payment arrangements with providers in their networks more recently.

A nationwide survey of health plans in 1999 found that 61 percent of health plans offering HMO products used capitation payments (versus fee-for-service or salary) to primary care physicians as their predominant payment method. In addition, 13 percent of plans paid capitation to specialists (Lake et al. 2000, Gold et al. 2002). At that time, many plans (86 percent) had risk-based contracts with intermediate organizations such as physician-hospital organizations (PHOs) or independent practice associations (IPAs). Of these plans, 64 percent reported at least one global risk or capitation contract covering all services including hospital and physician services, 52 percent reported professional service capitation contracts, and 14 percent had capitation contracts solely for hospital services. However, in most of the plans surveyed, relatively few enrollees (often less than 20 percent) were covered under such contracting arrangements with intermediate entities.

Global payments (or capitation) became more prevalent as enrollment in managed care products grew from the late 1980s to the early to mid-1990s, but subsequently declined by the late 1990s (Gold et al. 1995, Hurley et al. 2002). The estimated percentage of primary care physicians who received capitation dropped from 77 percent in 1997 to 67 percent in 2001 (Strunk and Reschovsky 2002). While capitation payments to specialists were less common, these arrangements also declined.

The 1990s also saw an increase in provider-sponsored risk-bearing entities, followed by a decline. During this period, many IPAs, PHOs, physician practice management companies (PPMCs), and integrated delivery systems (IDS) sought out risk-based payments, and many of these

companies failed(Brewster, Jackson, and Lesser 2000). Many of the existing systems no longer accept global risk.

Currently, the prevalence of global payment arrangements in Massachusetts is not well known. However, risk-sharing arrangements of various forms continue to exist—including recent developments such as BCBSMA's Alternative Quality Contract with organizations such as the Mt. Auburn IPA, which combines features of global payment with incentives for quality performance. Such contracts indicate ongoing interest in payment arrangements that share risk with providers and also reward them for delivering high-quality services.

6. Impact

Many studies have shown that payment approaches involving risk-sharing with providers—prominently including global payment or capitation—are associated with lower service use and cost, compared with fee-for-service arrangements. Such studies extend back to the RAND Health Insurance Experiment in the 1970s, continuing through the 1990s to the current decade.[1] Most focus on types of capitation arrangements implemented during the growth of managed care. The types of services studied varies widely, as do the data and methods used—controlling differently for patient characteristics and various features of the health care system that may affect use and cost of services. Not surprisingly, the estimated size of effects also varies widely.

In addition, the research literature on how provider risk-sharing affects outcomes such as access to care, quality of care, and patient or provider satisfaction is mixed (Davies et al. 1986; Udvarhelyi et al. 1991; Kao et al. 1998; Flocke et al. 1998; Rubin et al. 1993). For example, some studies show increased delivery of primary care or preventive services when providers receive capitation, but others show reduced access to care or reduced patient trust in their physicians. Like the research literature on use and cost effects, many of the studies on access, quality, and satisfaction are relatively old, and they vary widely in their methods as well as the populations and practice settings that they studied.

There is relatively little research on how global payment arrangements affect longer term outcomes such as provider integration or coordination of services across settings. Study of this topic is challenged by the longer-term nature of these effects and the difficulty of separating the effects of payment from effects of other relevant market trends (such as insurance product design or regulatory developments). However, there is considerable anecdotal evidence suggesting that many provider organizations that sought financial risk during in the 1990s were able to integrate financially but were unable to integrate delivery of clinical services across settings. Consequently, they were unable to manage care or contain costs under risk-sharing arrangements as they were designed at that time (Hurley et al. 2002; Brewster, Jackson, and Lesser 2000).

[1] See, for example: Buchanan 1992; Epstein, Begg, and McNeil 1986; Pauly et al. 1990; Johnson et al. 1989; Greenfield et al. 1992; Bradbury 1991; and Reschovsky, Hadley, and Landon 2006.

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Scale And Structure Of Capitated Physician Organizations In California

Market pressures have forced these organizations to change with the times, according to these survey data.

by Meredith B. Rosenthal, Richard G. Frank, Joan L. Buchanan, and Arnold M. Epstein

ABSTRACT: Physician organizations in California broke new ground in the 1980s by accepting capitated contracts and taking on utilization management functions. In this paper we present new data that document the scale, structure, and vertical affiliations of physician organizations that accept capitation in California. We provide information on capitated enrollment, the share of revenue derived by physician organizations from capitation contracts, and the scope of risk sharing with health maintenance organizations (HMOs). Capitation contracts and risk sharing dominate payment arrangements with HMOs. Physician organizations appear to have responded to capitation by affiliating with hospitals and management companies, adopting hybrid organizational structures, and consolidating into larger entities.

For a number of years researchers have recognized California as the cradle of a unique brand of managed care in which physician organizations assume financial risk and are delegated authority for managing the care of a population of health maintenance organization (HMO) enrollees.[1] To many, the notion of a system in which autonomous physician organizations rather than HMOs control a broad range of utilization management decisions holds great appeal. Wall Street, too, was enamored of the prospect of "physician-managed" care and provided capital that accelerated the development of a new industry (physician practice management, or PPM) to support medical groups and independent practice

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associations (IPAs) in managing capitated contracts. Recently, however, news out of California has taken a decidedly negative turn, with dire reports about the financial solvency of physician organizations and the viability of the delegated model.[2]

In California both health care providers and policymakers have begun to take steps to respond to the apparent crisis. There is a clear need to take stock of the delegated model and the physician organizations that accept capitation contracts. This information bears on the future shape of managed care in other markets as well, which have to varying degrees adopted capitation and delegation of utilization management as cost containment strategies. In this paper we describe the scale and structure of capitated physician organizations in California, the nature of their contracts with HMOs, and their affiliations with hospitals and management companies.

Data And Methods

We set out to survey all of the physician organizations in California that contract with PacifiCare Health Systems, the third-largest health plan in California and the fifth-largest in the nation. While the PacifiCare network was our starting point for identifying groups that accept capitation, our data relate to all of the contracts that are held by the physician organizations, which typically hold about ten HMO contracts. The physician organizations that contract with PacifiCare provide care for about 80 percent of all Californians that obtain their care through the delegated model.

To develop the survey instrument, we reviewed prior surveys of managed care and physician organizations and other relevant literature. We consulted with representatives of important organizations in the industry, including the American Medical Group Association, the National IPA Coalition, and the California Medical Association. We also carried out a series of case studies of physician organizations selected to represent the diversity of our sample.[3]

After identification of the physician organizations by PacifiCare, interviewers contacted each organization's medical director or chief executive officer (CEO) by mail and then made at least ten attempts to schedule and administer a telephone survey. Study participation involved a forty-five-minute structured telephone interview. The study was carried out between May 1999 and June 2000. A 97 percent response rate was obtained by our interviewers; only 4 of 157 potential respondents declined to be surveyed for the study.

The survey directed respondents to use the full year 1998 as the frame of reference for our questions, which addressed the following domains: structure and contracts, human resources, governance, financial incentives, utilization management, quality management,

and information systems. Here we report on findings from the domains of structure and human resources.

Survey Results

■ **Structure and scale of physician organizations.** We identify three types of physician organizations: medical groups, medical groups with an IPA wraparound, and IPAs. Medical groups are highly integrated organizations in which physicians are employees or participants in a partnership arrangement. With few exceptions, physicians belong to only one medical group and practice together in facilities (of which there are often several) owned and managed by the group. In contrast to medical groups, IPAs are decentralized physician organizations. Physicians typically have nonexclusive contractual relationships with IPAs and manage their own offices independently.

Our third category is a hybrid type: the medical group with IPA wraparound (simply "wraparound" hereafter). In the wraparound there is a core medical group that both delivers services and manages an IPA. In some cases, the wraparound may consist of two distinct legal entities with separate bottom lines. For the purposes of HMO contracting decisions and affiliations with hospitals and management companies, however, the entities we have identified as wraparounds operate as a single unit. To avoid double-counting a single set of organizational decisions, we have chosen to view each wraparound as a single entity. Where appropriate, we note how our results would be affected by considering each wraparound as an unrelated medical group and IPA. In addition, we show the numbers of primary care and specialist physicians separately for the core and IPA parts of the wraparound in Exhibit 1.

More than half of the physician organizations in 1998 were IPAs (Exhibit 1). Only about 15 percent of the organizations were pure medical groups; the remainder took the wraparound form (47 of 153 entities). If we were to treat wraparounds as two separate entities, one medical group and one IPA, we would find that about two-thirds of the organizations were IPAs and one-third, medical groups.

The most striking feature of capitated physician organizations in California is their sheer size in terms of numbers of physicians. Across all types, they averaged 343 total physicians each. Numbers ranged from 5 to 2,600, with a median of 216. Most, however, were large: Three-quarters of the organizations consisted of at least fifty physicians in 1998.

Wraparounds were the largest entities in terms of total physicians, with 83 core physicians plus 296 IPA physicians on average.

EXHIBIT 1
Distribution Of Physician Organizations In California, By Size And Model, 1998

	Medical groups	IPAs	Wraparounds		All types
			Core	IPA	
Physician organizations	25	81	47	47	153
Primary care physicians					
Mean	57	111	41	34	91
Median	42	75	23	24	56
Specialists					
Mean	152	253	41	261	252
Median	40	180	6	147	150
Total physicians					
Mean	209	364	83	296	343
Median	93	236	33	170	216
Capitated lives					
Mean	49,708	43,779	66,194	–[a]	51,538
Median	41,900	27,500	34,750	–[a]	31,000

SOURCE: Harvard University survey sponsored by the California HealthCare Foundation.
NOTES: Wraparounds are treated as single entities for the purpose of enrollment. However, we show numbers of physicians separately for the core medical groups and independent practice associations (IPAs) within wraparounds. The total number of organizations counts the wraparounds only once.
[a] Capitated lives for wraparound IPAs are included in the figure listed under "wraparound core" (see Notes).

Comparing the components of the wraparound to pure medical groups and IPAs, we find that the wraparound relationship is undertaken by smaller-than-average medical groups and IPAs. IPAs were a close second to wraparounds in terms of scale, averaging 364 member physicians. Medical groups, while smaller than their wraparound and IPA counterparts, were quite large by national standards. According to the American Medical Association (AMA), the average U.S. medical group consisted of nine physicians in 1996.[4] The average medical group in our sample contained 209 physicians (the median was 93).

Capitated physician organizations in California are predominantly multispecialty. Only three of the 153 organizations were restricted to primary care physicians; none excluded such physicians. Nationally, about 70 percent of medical groups are single-specialty.[5]

The impetus toward organizations of a larger scale is apparent not just from the cross-sectional description in Exhibit 1, but also from reports of merger activity. More than half (56 percent) of the groups that we interviewed participated in some type of merger or acquisition between 1996 and 1998. Mergers were somewhat less common among IPAs than among other organizational types.

■ **Capitated enrollment.** The average total capitated enrollment for physician organizations in our sample was 51,538 (Exhibit 1). There was a wide range in capitated enrollment, from about 700 to

"The ability of physician organizations to accept and manage capitation contracts is partly a function of their scale."

700,000, with a median of 31,000. As was the case with the number of physicians, the wraparounds had the greatest total capitated enrollment. Medical groups, however, were larger on average by this measure than IPAs. Because there are more than three times as many IPAs in the sample as medical groups, however, IPAs account for just under half of all capitated patients.

The physician organizations accept capitation contracts that cover enrollees in commercial, Medicare, and Medi-Cal (California Medicaid) plans. Roughly 80 percent of all capitated enrollees cared for by these groups are in commercial plans. This figure understates the importance of Medicare in terms of capitated revenue, however, since Medicare capitation rates are several times higher than commercial rates.

■ **Affiliations.** The ability of physician organizations to accept and successfully manage capitation contracts is partly a function of their scale, but it may also be enhanced by their ties to hospitals and PPM companies. Such affiliations offer physicians access to external risk sharing, financial capital, and management expertise.[6] Whether affiliations take the form of ownership, long-term contracts, or informal arrangements is driven by a number of factors including regulatory constraints and tax considerations. Rather than restricting our analysis to legal integration (ownership), we describe the prevalence of self-reported affiliations of any type.[7]

Hospitals. Historically, most physician organizations in California have maintained their independence from hospitals.[8] Moreover, California law makes the acquisition of physician organizations by hospitals challenging. Hospitals other than academic medical centers generally must set up a "medical foundation" to purchase physician organizations. Only about 20 percent of physician organizations overall were affiliated with a medical foundation in 1998, and this was four times as likely among medical groups as among IPAs (Exhibit 2).

While vertically integrated entities are still relatively rare, many physician organizations maintain close ties to one or more hospitals. The use of a preferred hospital can be advantageous for a physician organization in managing use of hospital services because of increased leverage and the potential for improved coordination (for example, for discharge planning). Overall, 92 percent of physician organizations indicated that they channeled their admissions to one

EXHIBIT 2
Vertical Affiliations Of Physician Organizations In California, By Model, 1998

	Medical groups	IPAs	Wraparounds	All types
Affiliated with an MSO/PPM	80%	96%	79%	88%
Affiliated with a foundation	44%	10%	27%	21%
Have primary or preferred hospital(s)	96%	85%	91%	92%
Number of preferred hospitals	2	3	8	4

SOURCE: Harvard University survey sponsored by the California HealthCare Foundation.
NOTES: IPAs are independent practice associations. MSO is management service organization. PPM is physician practice management company.

or several preferred hospitals (Exhibit 2).

Management companies. In the 1990s management service organizations (MSOs) and PPM companies proliferated in California. These firms range in complexity and sophistication from the incorporation of the back-office functions of a single group to publicly traded entities that manage practices across the nation. Nearly 90 percent of the physician organizations had either an ownership or a contractual relationship with an MSO or a PPM in 1998 (Exhibit 2). This was most common for IPAs.

■ **Importance and scope of capitated contracts.** We are interested in understanding the financial aspects of the contracts that the physician organizations hold with health plans for two intertwined reasons. First, we want to assess how much risk these entities accept for the cost of care. We judge risk in part by the scope of services included in capitation contracts. Second, we want to know how important these contracts are to the physician organizations by looking at what share of their revenue takes this form. The share of revenue from capitation tells us how dependent the organizations are on this type of contract and thus how strongly motivated they will be to adapt organizational features to capitation incentives.

We asked the physician organizations to break out their revenue according to the following methods of payment: discounted fee-for-service (FFS), FFS with withhold, professional capitation, professional plus ancillary capitation, and global capitation (Exhibit 3). Overall, 84 percent of patient care revenue for the groups in our sample came from some kind of capitation contract. The majority of the capitated revenue came from contracts in which professional or professional plus ancillary services were included in the capitation payment and hospital risk was shared rather than fully delegated to the physician organization. The inclusion of full hospital risk in the scope of the capitation payment ("global capitation") was less common. This latter type of contract constituted about 15 percent of revenue on average and was concentrated among a minority of phy-

EXHIBIT 3
Patient Care Revenue Payment Methods Among Physician Organizations In California, By Model, 1998

Method	Medical groups	IPAs	Wraparounds	All types
Discounted FFS	23%	7%	21%	14%
FFS with withhold	2	2	2	2
Capitation contracts with shared hospital risk				
Professional capitation	15	14	11	13
Professional and ancillary capitation	43	65	47	56
Global capitation	17	12	19	15

SOURCE: Harvard University survey sponsored by the California HealthCare Foundation.
NOTES: IPAs are independent practice associations. FFS is fee-for-service.

sician organizations (thirty-two).[9]

The primary difference in revenue composition by organizational form is between IPAs and the more integrated physician organizations. On average, 25 percent of revenue for medical groups was derived from FFS contracts, similar to the 23 percent for wraparounds. By contrast, the IPAs in the sample received only 9 percent of their patient care revenue from FFS contracts. This reflects the fact that many IPAs exist primarily to negotiate and manage capitation contracts for their member physicians, who deal directly with health plans for their FFS clients.

As noted above, shared risk arrangements for hospital costs typify capitation contracts in California. Risk sharing for hospital costs is generally structured as a "risk pool" in which a spending or utilization target (such as bed days) is set and cost savings or overruns relative to the target are shared between the physician organization and the HMO (and possibly a hospital) according to a predetermined formula. This is also the case for pharmacy costs. Sixty-three percent of the groups that we interviewed had some type of shared risk arrangement for their pharmacy contracts.

Discussion

Our study underscores several important features of physician organizations that are not well documented in the literature. First, we found a substantial number of medical groups undertaking a new business strategy that involves managing their own IPA: the so-called wraparound.

Wraparounds serve a number of functions, many of which involve exploiting economies of scale while maintaining the flexibility that large staff-model organizations lack. Three distinct rationales for group practices to develop wraparound networks are commonly

"Pharmacy and hospital risk sharing have declined as a result of the consumer and provider backlash in California."

offered. The first is to channel volume through a limited number of specialists. Concentrating referral volume should improve the negotiating position of the group, reduce transaction costs, and facilitate clinical coordination between primary care physicians and specialists. For a medical group that accepts professional or global capitation, outside referrals can be a major source of costs. Indeed, out-of-group referrals are 18 percent of professional spending in medical groups and only 10 percent for wraparounds, while the wraparound itself absorbs about 43 percent of the revenue that flows into the medical group. The second rationale for a wraparound is to improve geographic coverage of the group in terms of primary care physicians and/or specialists. A third reason that medical groups have constructed their own IPAs is to open up new channels for referrals into the group. That is, the wraparound can be designed to include primary care physicians who provide business to specialists employed by the medical group (much like the way hospitals elsewhere have purchased primary care practices to "feed" their beds).

The dominance of less integrated organizational forms (IPAs and wraparounds) mirrors the structure of HMOs today, where staff-model organizations are a shrinking minority. The same factors that have led to the dominance of IPA and network-model HMOs are likely responsible for this pattern: the desire of consumers to have choice of providers and sites of care, the desire of physicians to operate independently (that is, not as employees), and the diseconomies of scale associated with integrated physician practice.

Compared with the nation as a whole, capitated physician organizations in California appear to be larger and more likely to be multispecialty. Both of these structural features may reflect the demands of managing capitation contracts. Because more than 80 percent of their patient care revenue derives from capitated sources, risk spreading is critical to these organizations. Similarly, multispecialty organizations may be in a better position to control health care spending than single-specialty organizations are, because of improved coordination.

There has been great concern in California about the scope of risk sharing with physician organizations. Our results indicate that most of these organizations accepted risk for both hospital care and pharmacy in 1998. Pharmacy risk sharing in particular has been a source of great controversy because of its association with heavy

financial losses among capitated physician organizations in California. First, pharmaceutical spending is growing rapidly everywhere; nationally it grew by 18 percent in 1999.[10] Second, physician organizations may not have full control over pharmacy utilization; they often do not get detailed utilization data, and other entities (primarily pharmacy benefit managers, or PBMs) control formulary design.[11]

There have been substantial changes in risk-sharing arrangements between HMOs and physician organizations in the short time since this study was undertaken. Both pharmacy and hospital risk sharing have been greatly reduced as a result of the consumer and provider backlash in California against the use of these payment strategies. This is not the case for professional services, for which capitation remains prevalent in California.

Our study confirms prior research on California physician organizations in showing that they are large, multispecialty entities that are deeply involved in the business of managing capitated contracts.[12] In fact, our results amplify these conclusions: We found California physician organizations to be larger and taking more risk for the cost of care than prior surveys have found. These findings may reflect two related trends at the end of the 1990s in California: (1) consolidation of physician organizations into larger entities, and (2) increased use of risk sharing and delegation of utilization management.

Our results should be interpreted in light of several strengths and weaknesses of the study. Its primary strengths are the high response rate (97 percent) and the detailed data we were able to collect from knowledgeable respondents. In addition, because California is a bellwether state for managed care and for the "delegated model" in particular, our study gives an excellent picture of what is happening at the cutting edge of provider capitation. On the other hand, because California is an outlier relative to the rest of the nation, these results may not be generalizable to other markets. The other primary weakness of the data has been hinted at above: The market dynamics in California render even the most current survey data somewhat out of date.

Physician organizations in California have undergone a number of structural transformations as a result of market pressures. The formation of wraparounds as a strategy for growth and cost containment is the most notable of these changes. In addition, we found evidence of mergers and acquisitions resulting in larger organizations than previously noted. Risk sharing is pervasive, in terms of both the share of revenue from capitation and the scope of services covered by risk-sharing arrangements. Two key factors examined here mitigate the risk exposure of physician organizations: their affiliations with MSOs, PPMs, and hospitals; and their large size.[13]

Despite these factors, there is still a good deal of financial pressure on physician organizations in California. During the past several years a substantial number of physician organizations and PPMs have failed. From 1998 through 2000 thirty-one medical groups or IPAs in our sample went out of business, along with (and often because of) the failure of three major PPMs.[14] These failures have had a wide range of immediate and long-term effects. In terms of immediate effects, when medical groups fail, physicians may be left without a practice and patients without a source of care. IPA (and some PPM) failures most directly affect financial flows and contractual relationships, since physicians have independent practices. In the longer term, the failure of physician organizations in California appears to be changing the nature of risk arrangements and stimulating more stringent regulatory policy toward physician organizations and HMOs that use the delegated model.

WHETHER AND HOW PHYSICIAN ORGANIZATIONS will thrive under capitation in the future is a pressing question in and beyond California. What is needed, in particular, is some understanding of what predicts the success or failure of a risk-bearing physician organization. While no causal relationship can be established from our data, and the number of failures is too small even to detect statistical associations, there are some apparent patterns among these failures. Failed physician organizations were more likely to be IPAs, less likely to be affiliated with a foundation, and somewhat larger than average (within their organizational type). These data provide a starting point for important future research on the delegated model.

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13. A third factor that reduces the risk exposure of capitated physician organizations is stop-loss insurance. Ninety-four percent of the physician organizations in our survey reported having some form of stop-loss coverage.
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A Longitudinal Perspective On Health Plan–Provider Risk Contracting

Despite some broad national trends, the growth of risk arrangements depends on local market circumstances, capacity, and interest.

by Robert Hurley, Joy Grossman, Timothy Lake, and Lawrence Casalino

ABSTRACT: During the past decade many health plans adopted risk-contracting arrangements that transferred substantial financial risk and care management responsibility to physician groups and hospital-sponsored integrated delivery systems. Risk transfer arrangements are now believed to be in steep decline, but there is little empirical evidence on this topic, particularly at the local-market level. Data from the Community Tracking Study were used to examine changes in risk contracting from 1996 to 2000. A decline in reliance on risk contracting is evident in nearly all markets. However, retrenchment in risk contracting has followed different patterns ranging from refinements in the scope of risk transfer to reduced use of risk arrangements to total rejection of risk-sharing arrangements. Modified risk-transfer agreements remain viable in several markets, but continued refinement in the nature and scope of risk sharing will be necessary.

IN THE MID-1990S IT WAS EXPECTED that transfer of substantial financial risk and care management responsibility from health plans to physician groups and hospital-sponsored integrated delivery systems would become a dominant arrangement in health maintenance organizations (HMOs).[1] Risk contracts appealed to health plans seeking to curb medical expense growth and to physicians and hospitals anxious to restore or preserve a measure of autonomy in care delivery.[2] Although characterized as a "California model" by some, these arrangements became a strategy of many health plans across the country.[3]

By the end of the decade some observers were contending that a "flight from risk" had occurred.[4] Loss of enthusiasm was attributed to poor utilization management, inadequate payments by health plans, and diminished savings opportunities as further reductions in service use and cost became more difficult.[5] In addi-

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tion, a consumer and physician backlash engendered skepticism about health plans' methods and motives. Plans became more cautious about the use of incentives and increasingly offered broad-network, open-access (no gatekeeper) products that make it difficult to manage care and transfer risk.

Despite a belief that risk transfer is in steep decline, there is little empirical evidence on this topic, particularly at the local-market level.[6] We find important differences in the trajectory of risk across markets, given the differing configurations of physicians and health systems, diverse health plans, and varying past experience with risk arrangements. Changes in risk-based arrangements range from refining the scope of services under risk in some markets to reductions in plan membership under risk transfer in others to full rejection of risk in still others.

Background

Although the desirability of risk arrangements has been long debated, there is a general consensus that risk promotes cost-conscious provision of health services, leading health plans to use risk extensively in HMO products.[7] Health plans may transfer financial risk to provider organizations for primary care services only ("primary care capitation") or include specialist physician services as well ("professional risk"). Some risk arrangements also cover hospital and ancillary services and pharmaceuticals (referred to as "shared risk" or "global risk"). We distinguish between global and shared risk based on whether the contracting organization accepts full risk for inpatient care or the risk is shared between the health plan and the physician groups or physician-hospital organization (PHO).

From a provider perspective, a distinction in risk transfer is sometimes made between "business risk" and "insurance risk."[8] Business risk is risk for services over which the provider organization can reasonably be expected to exert at least a moderate degree of control, such as physician, ancillary, or hospital services. Insurance risk includes services over which providers have little or no control, as in the case of pharmaceutical costs, new benefit mandates imposed during a contract period, or out-of-network service use by plan members.

Some health plans have promoted or permitted risk contracting because they believe that the "delegated model" is important as a means to change the behavior of physicians and hospitals. It may also enable plans to limit their medical expense exposure by shifting financial risk for care, to reduce their administrative costs of managing care, and to lessen friction with providers who have chafed under micromanaged care. Physicians and hospitals have viewed assumption of risk as a way to reduce external interference in clinical decision making and to reap the gains of cost reductions that changes in their practices may yield. In addition, since capitation payments are not tied to generating procedures and office visits, physician and hospital organizations can use the budget capitation provides to promote preferred practice behavior and to achieve organizational goals.

Efforts by physicians and hospitals to create new organizations came into

vogue in the early 1990s and included integrated delivery systems (IDSs), independent practice associations (IPAs), PHOs, and physician practice management (PPM) firms, as well as the extensive purchase of physician practices by hospitals.[9] Many saw risk contracts as an important complement to other contributing factors, a kind of physiological change to shape and sustain the anatomical changes represented by these new organizations. Despite these broad national developments, the growth of risk arrangements remained highly dependent on local market circumstances, capacity, and interest.[10]

Study Methods

The Community Tracking Study (CTS) is a multiyear, multimethod project of the Center for Studying Health System Change (HSC) to analyze patterns of change in a representative sample of sixty markets.[11] Twelve metropolitan markets with populations over 200,000 were randomly selected for in-depth study, with intensive site visits conducted in 1996, 1998, and 2000. The site visits include protocol-driven telephone and in-person interviews with fifty to ninety informants in each site representing purchasing, health plan, policy, physician, and hospital sectors. A total of 2,220 interviews have been conducted across the twelve sites during the three rounds. In addition, every two years HSC surveys households (with a follow-back survey to explore type of insurance questions) and physicians in the sixty markets. We use results from the 1996–97 CTS Followback Survey to benchmark risk contracting at that point in time.

Data for this study are drawn primarily from 210 interviews conducted between June 2000 and March 2001 with executives from three to six health plans in each market—a total of forty-one plans. Selected plans include market leaders among regional and national plans, and local Blue Cross/Blue Shield plans. In addition, 256 administrative and clinical leaders in the major health systems and physician organizations were interviewed in the twelve markets. Respondents were asked about contracting arrangements, experience with various configurations of risk transfer, and changes made in network arrangements. All interview notes were incorporated into qualitative data analysis software for coding and analysis.

Study Results

Data from the 1996–97 survey and interview results from Round 1 site visits were used to sort the twelve markets into three broad clusters based on the amount (number of covered lives) and scope (services incorporated under risk payments) of risk contracting (Exhibit 1). In this study we focus on professional and global or shared risk contracts. Orange County in Southern California, where shared risk arrangements have been the dominant form for HMO networks for a number of years, is the only market placed in the extensive-risk cluster. At the other extreme, with limited risk, are Little Rock, Lansing, Greenville, and Northern New Jersey, where risk transfer was typically used by a single plan with a sin-

EXHIBIT 1
Health Plan Risk Contracting In Community Tracking Study (CTS) Sites, 1996–1997

Study site, by degree of risk contracting	Percent of privately insured in products that use risk contracts	Most common risk contracts[a]	Provider organizations contracting with health plans for risk[b]
Extensive			
Orange County	56%	Shared, professional	Medical group, IPA
Moderate			
Seattle	26	Global, professional	IDS/PHO, medical group, IPA
Miami	25	Global, professional	IDS/PHO, IPA
Phoenix	21	Professional, global	IPA, IDS/PHO
Cleveland	19	Professional, global	IDS/PHO, IPA
Indianapolis	17	Global, professional	IDS/PHO, medical group
Boston	15	Shared, professional	IDS/PHO, medical group
Syracuse	13	Global, professional	Medical group, IPA
Limited			
Little Rock	8	Professional	Medical group
Lansing	3	Professional	Medical group
Greenville	2	Professional	Medical group
Northern New Jersey	2	Professional	IPA

SOURCES: Percentage of privately insured in products that use risk contracts is from the 1996–97 Community Tracking Study Followback Survey. Other data are based on interviews conducted during CTS site visits in 1996–1997.

NOTES: All measures exclude risk contracts that cover primary care services only.

[a] Professional risk includes primary care and specialty services; global and shared risk covers primary care and specialty and hospital services. Under global risk, the contracting entity takes full risk for inpatient care. Under shared risk, the risk is shared between the contracting entity and the health plan.

[b] IDS/PHO is integrated delivery system contracting through a physician-hospital organization. IPA is independent practice association.

gle medical group or IPA.

The moderate-risk cluster of markets is more heterogeneous, with the amount and types of risk arrangements being quite varied. In these markets risk contracting was receiving considerable attention from a number of plans and providers in 1996 but was not yet in widespread use. In Miami and Cleveland, for example, risk arrangements were most commonly found in a single product line such as Medicare or Medicaid. In Boston large hospital-based systems formed in the mid-1990s contracted with some health plans to share risk among plans, systems, and affiliated physicians. In Indianapolis the largest HMO product was offered by a network-based health plan having global risk contracts with nearly twenty different provider organizations. Syracuse had a similar but smaller-scale network plan that limited the scope of risk transferred.

Our findings examine plan-to-provider risk transfer, and thus our market characterizations are based on how sampled plans employed risk arrangements across the twelve markets. It also is apparent that provider organizations in these markets fall into three broad categories. Some groups were accepting extensive (global or shared) risk across most contracts in 1996; other groups took less risk,

by virtue of fewer contracts or more limited scope in their contracts; and still other groups had limited risk experience, meaning few contracts and typically only professional risk. While our focus in this paper is on plan-to-provider contracting, we also note changes that occurred among provider groups.

■ **1996 interviews.** Round 1 interviewees in all markets expected both HMO enrollment and risk contracting to grow rapidly in commercial and Medicare lines of business. This was particularly true in metropolitan markets such as Indianapolis and Northern New Jersey, where HMO enrollment had lagged behind national trends or where the Medicare HMO market was seen as a growth opportunity for plans, as in Boston and Cleveland. Expectations of growing reliance on HMO revenues led physicians and health systems to position themselves to "move up the food chain," which meant both seeking risk transfer contracts and expanding care delivery capacity through acquisitions or strategic affiliations and alliances.

Medical groups and IPAs in Orange County were already deeply involved in shared risk arrangements with plans that included pharmacy and other ancillary services. In other markets with less experience with risk arrangements, hospital systems and physician organizations were being created as necessary transitional steps to enter into global and shared risk contracts. A notable example was the formation in Boston of two large integrated systems, Partners and CareGroup. PHOs and IPAs emerged in other markets in this period, with hospitals playing an integral role in the former and physicians usually providing the leadership in the latter. PHOs enabled hospitals and their affiliated physicians to enter into global or shared risk arrangements as IDSs. Freestanding IPAs and medical groups typically limited contract scope to professional or shared risk. Phoenix, Seattle, Cleveland, Indianapolis, and Syracuse saw substantial development of such models. Small, embryonic IPAs also arose in some of the markets in the limited-risk cluster.

The viability of risk-transfer arrangements in the moderate- and limited-risk market clusters hinged on plans' willingness to enter into contracts with newly organized and unproven entities. Some health plans encouraged their growth, while others were skeptical about these entities' capacity to perform risk-bearing roles. There was especially strong support for risk-bearing entities in the Medicare HMO product, since risk arrangements—typically global or "percentage of premium" contracts—were seen as key in encouraging physicians to reduce the large inpatient expenses of Medicare and to share in the savings that resulted. Plans with well-established networks with individual physician and hospital contracts already in place, such as Blue Cross Blue Shield plans, were less enthusiastic about risk arrangements.

■ **1998 interviews.** The Round 2 interviews found that efforts to promote risk transfer set in motion in Round 1 had paid off in several markets. But many provider organizations found it more difficult than expected to profit from risk contracting, and some suffered heavy losses. Insurance premiums had risen little between Rounds 1 and 2. Correspondingly, capitation payments were flat and lagging behind

increases in costs, especially as prescription drug costs began to rise, adversely affecting those organizations that were at risk for these services.

Reductions in service use had been expected to provide savings that would accrue to risk-contracting physicians and hospitals. But in some markets reductions in use had already been made, making further savings difficult. In other markets where such reductions had not yet been made, plans and providers found it difficult to institute effective utilization management. Meanwhile, a consumer backlash challenged managed care techniques, including capitation and utilization management. Health plans began to modify products and practices, shifting emphasis away from HMOs and traditional risk arrangements toward point-of-service (POS) and preferred provider organization (PPO) products.[12]

Orange County witnessed the collapse of major PPM firms that had tried to aggregate market clout by purchasing medical groups and managing IPAs.[13] Although the failures had many causes, interviewees in several markets saw them as a direct challenge to the soundness of the "California model" of risk transfer. These failures and similar but smaller-scale failures of risk-bearing physician organizations in northern New Jersey and Phoenix provoked regulatory attention in all three states, raising doubts about and, in some cases, barriers to risk contracting.

In markets with moderate or limited risk-transfer experience, caution became the watchword. Plans with interest in risk contracts found fewer organizations willing and able to assume and manage risk, especially risk for services over which providers could not exert much control. In midsize and small markets such as Indianapolis, Lansing, Greenville, Little Rock, and Syracuse, the role of dominant local hospital systems was typically a determinant. Some systems had originally embraced risk as a way to lock in specialty and hospital referral relationships through PHOs that accepted global capitation, such as in Indianapolis. But many health systems lost money on their risk contracts, and, over time, most failed to receive enough patients through risk contracts to effect changes in behavior or to justify major investment in management systems and infrastructure. Enthusiasm faded for initiatives that did not grow revenue and consumed resources. Many systems also found that integration efforts between physicians and hospitals were not progressing, and distribution of risk payments among primary care physicians, specialists, and hospitals became a troublesome management issue.

■ **2000 interviews.** Round 3 interviews revealed several notable developments since 1998 with important implications for risk transfer. Plans had begun to obtain sizable premium increases from purchasers, and providers expected to receive corresponding increases in capitation payments. Financial distress, attributed in part to the Balanced Budget Act (BBA) of 1997, also led many physicians and hospitals to demand higher payments from health plans and threaten to refuse to continue to participate in networks unless their demands were met.[14] Already facing serious discontent among consumers and employers, health plans acceded to these demands in order to keep networks intact in many instances.

Hospitals also began to refuse to accept risk-based payments, putting global capitation arrangements in jeopardy and making shared risk arrangements less practical. As one hospital executive stated, "We have a basic belief that we don't belong in and don't want to be in the insurance business." Physicians also challenged the scope of their risk contracts because of their discomfort with the amount of insurance risk they had assumed. This pushing back led many plans to agree to exclude from risk contracts pharmaceuticals and benefit and service mandates that providers contended they could not be expected to influence, particularly when mandates were implemented after contracts were already in place.

Change in risk-contracting practices between 1998 and 2000 in the forty-one health plans interviewed in Round 3 falls into several patterns (Exhibit 2). While overall only three fewer plans engaged in risk transfer in 2000 (23) than in 1998 (26), the scope of risk transferred was reduced, and plans became more discriminating in selecting risk-contracting partners. Despite turmoil in Orange County related to PPM failures and the refusal of some hospitals to continue risk arrangements, all major health plans there remain committed to the "delegated model." But the price of sustaining this commitment has been large payment increases to shore up contracting medical groups, IPAs, and hospitals. In addition, in five of the six plans there has been refinement in the scope of contracting, including taking back some pharmacy risk and reducing the impact on risk-bearing entities of state regulations such as mental health parity and mandated immunizations, elements of "insurance risk" that providers consider unacceptable.

In the cluster of markets with limited risk-transfer experience, very few physicians, hospitals, or health plans were ever enthusiastic about risk contracting, and

EXHIBIT 2
Changes In Health Plan Risk Contracting Between 1998 And 2001 In Community Tracking Study (CTS) Sites

	Risk contracting				Changes made in risk contracts between 1998 and 2001	
	1998–1999		2000–2001			
Study site, by degree of risk contracting	Number of plans	Percent of plans with risk (number)	Number of plans	Percent of plans with risk (number)	Percent of plans reducing scope of risk contracts (number)	Percent of plans reducing members under risk contracts (number)
Extensive	6	100%	6	100%	83% (5)	0%
Moderate	23	74% (17)	23	65% (15)	29% (5)	47% (8)
Limited	12	25% (3)	12	17% (2)	0	67% (2)
Total	41	63% (26)	41	56% (23)	38% (10)	38% (10%)

SOURCE: Data are based on interviews conducted during Community Tracking Study site visits in 2000–2001.
NOTES: See Exhibit 1 for sites in each risk-contracting category. Data reflect the risk contracting of the interviewed health plans in 1998–1999 and 2000–2001. The statistics are aggregated over all interviewed plans in each of the site clusters. Risk contracts include professional, shared, and global risk arrangements and exclude risk contracts for primary care services only.

it was used in only three of the fifteen plans. One plan discontinued all risk, and the remaining two have fewer risk contracts and fewer lives under these contracts. PHOs and IPAs have been dismantled or have become inactive. HMO product growth has also stalled or is in decline, with nonrisk PPOs the product of choice. Notably, the dominant insurer in each market is a Blue Cross Blue Shield plan that had made minimal investment in HMO products and risk contracting.

The markets in the moderate-risk cluster reveal a mixed picture. Between 1998 and 2000 only two of the twenty-three plans interviewed had dropped all risk-transfer contracts, but other forms of retrenchment were evident. Five plans had reduced the scope of risk delegated, and eight plans reduced the number of members covered by risk contracts by contracting with fewer risk-bearing provider organizations. Seattle typifies this pattern: Plans found fewer organizations willing to accept risk contracts, resulting in fewer plan members under risk arrangements.

Risk arrangements remained in place for some members because plans were willing to undertake major changes to salvage them, including increased payments or carving out of pharmacy and other risk from contracts. In other cases, as in Cleveland and Miami, risk-transfer agreements remain principally in use in the Medicare market, although they could be in future jeopardy because of Medicare+ Choice policy changes. In Boston, where risk transfer has been in moderate use, plans have had to relent to pressures for large payment increases for health systems that are still reassessing their posture toward risk. One executive characterized the change as "a more thoughtful approach to risk, as opposed to the huge stampede toward risk five years ago." In Indianapolis and Syracuse a single health plan continues to rely on risk contracts. However, in all of the markets in this category, some physician organizations or health systems have achieved enough success in risk contracting to retain support for these agreements, even as other plans and providers eschew them.

Discussion

This longitudinal perspective on twelve randomly selected metropolitan areas provides valuable insights into the extent of risk contracting and how it has evolved as experience has accumulated and broader market conditions have changed. A number of patterns are apparent, including both sizable rate increases and retrenchment. Retrenchment is occurring in two forms: (1) reduction in the scope of services for which providers will accept risk to something closer to business risk; and (2) reduction in plan members covered under risk because fewer provider organizations are willing to participate in risk contracts.

In Orange County, with established medical groups and integrated systems that embraced risk transfer, risk arrangements remain in place, but their scope has been refined to exclude some services providers believe they cannot control, and payment rates have been increased. For markets where risk transfer has been employed more tentatively, such as Seattle, Indianapolis, and Cleveland, the picture

is one of a broader retreat in terms of both narrowing the scope of risk arrangements and reducing the number of HMO members covered under risk-transfer arrangements. Substantial capitation rate increases have also been reported in these markets. In the markets with limited risk-transfer experience, risk rejection is evident, with few if any risk-transfer arrangements likely to survive.

The success of risk transfer in a local market hinges on several factors: (1) plans' competence in selecting suitable risk-contracting partners; (2) presence of provider organizations willing and able to manage risk; (3) ability of plans and providers to agree on the appropriate scope of services for which risk can be transferred; and (4) adequacy of capitation payments to providers. Lack of growth in risk-transfer arrangements appears to reflect the fact that few new provider organizations have developed an interest in taking on the risk and responsibilities these arrangements entail, or the capacity to do so. For plans and their risk partners that have stepped back from these arrangements, risk transfer is unlikely to reemerge in the near term as an important strategy.

It is clear that plan payment rates have to meet provider expenses over time to sustain risk transfer arrangements, but that has not been the case in many instances for a number of reasons. Some providers have been overly optimistic about their ability to manage care. Others may have been naïve in rate negotiation and actuarial estimation. Still others accepted risk for costs they could not be expected to control, or they encountered unexpectedly large cost increases. In other situations, plans may have used the threat of exclusion from their networks to gain providers' acceptance of what proved to be inadequate rates, or refused to include realistic updates to reflect changing conditions.

OUR EVIDENCE CANNOT ADDRESS fundamental questions of whether transfer of risk provides a better mechanism for generating and sustaining cost savings by devolving more control to physicians, or how risk contracting, and the provider reorganization that it requires, affects the quality of care.[15] It is possible that savings and financial success achieved in some cases by risk-bearing providers resulted because of more effective care management, especially of inpatient services. Alternatively, some apparent success could have been an artifact of timing relative to the health insurance underwriting cycle. More research is needed to assess the impact of risk transfer on cost savings and quality.

Where risk contracting is well entrenched, there appears to be a reasonably high comfort level between plans and physician organizations with the division of responsibility and the amount of autonomy for patient care that it affords physicians. Despite the tumultuous experience of the past few years in Orange County, few observers there are predicting a radical change in reliance on risk transfer.[16] Seattle, Boston, Cleveland, and Indianapolis also continue to have risk-contracting relationships between health plans and provider organizations, although their futures are less certain. Given that the search for a modicum of peaceful coexis-

tence between health plans and physicians and hospitals is far from over, models that have durability and mutual commitment should not be discounted.

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